rent activity is a direct outcome of the monumental work of the Committee on the Costs of Medical Care. This group, working over a period of six years, from 1927 to 1933, produced 28 volumes which contain the justification and prescription for such activities as group practice, health maintenance organizations, quality control of medical practice, regulation of hospitals and nursing homes, provision of preventive medical services, improved medical, nursing, and auxiliary training, group payment, and indeed a total national health (medical care) service.[3] It is not surprising that the committee, its reports, and many of the proposals arising from them, were anathema to much of organized medicine. Fortunately, time has allowed a more objective view to be taken of these matters and, while some of the issues remain volatile, there is general agreement that the organization and delivery of medical care on a community or social base are legitimate concerns of the medical as well as the public health establishment.

Earlier I asserted that a distinction should be made between community or public health on the one hand and community medicine on the other. This position is based on a model of the relationship between health and disease and their care-systems which is illustrated in Chart 1. Health and disease are viewed as a continuum with "optimum" health at one end and death at the other. The intermediate points on the spectrum are altered health states, preclinical, and clinical disease. There are a variety of inputs into this system which influence each individual's position in it. It seems obvious that only some of these inputs are medical. In fact, a strong case can be made that the most influential inputs are not medical but rather genetic, environmental, social, behavioral and economic.[2,3] Some of these inputs are planned and purposefully applied and some are completely uncontrolled by the individual. In my view the total pattern of interaction—purposeful, and uncontrolled, medical and non-medical—should be the perspective of community or public health, while only those activities which are purposeful and clinical should be considered medical care and their organization and delivery be called community medicine.

Thus, community medicine involves planning, organizing, financing, and administering an organized system of medical care to a defined population. The scope of activity should include preventive, curative, and rehabilitative medicine. It should include provisions for quality control and evaluation of coverage. It should also include provision for the necessary facilties to provide this broad spectrum of clinical services. Finally, to be optimally effective a community medicine program should be integrated into a comprehensive public health activity which addresses all of the factors—social, behavioral, cultural, environmental, and economic—which influence and determine the health of the population and its burden of disease.

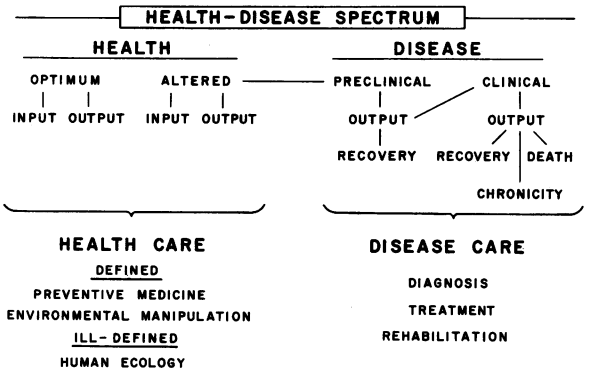

Chart 1.—A model illustrating the relationship of health and disease and their care systems.

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Refer to: Taylor D, Breslow L: Community medicine at University of California, Los Angeles, *In* Community Medicine —A Symposium. Calif Med 118:82-85, Apr 1973

University of California, Los Angeles

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COMMUNITY MEDICINE has recently become one of the most rapidly growing aspects of medical education in the United States, suddenly appealing to a large number of medical students and faculty.

It may be defined as a movement in medicine

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aimed at adapting medicine more closely to community needs, and thus has a different focus from that of preventive medicine (individual or mass prevention of disease) or public health (organized community effort to advance health). This new movement in medicine is responding to such complaints as: decline of the family physician, with relative overemphasis on other specialties; inadequate physicians in "underserved" areas, with abundance in Beverly Hills; academic medicine an "ivory tower," pursuing its own agenda not related to the health needs of people; too few Black and Spanish-speaking physicians and other health care personnel to adjust medicine to large and growing minority groups in the population.

The effort to overcome the problems represented by these complaints takes many forms, including academic changes. At UC,LA the strategy involves the entire Center for the Health Sciences.

All the health professional schools at UC,LA have embarked on serious programs to recruit minority students: 36 among 179 entering graduate students in public health in 1972 were from minority groups, 23 of 144 entering students in medicine, 23 of 105 in dentistry, and 22 of 166 graduate students and 30 of 102 undergraduate students in nursing.

Approved family practice residency training programs have been established through the initiative of UC,LA Department of Medicine faculty members at three hospitals associated with UC,LA. A recent "Evening With Family Medicine" organized by the director of the Santa Monica Hospital Family Practice Residency Training Program, a member of the faculty of the Department of Preventive and Social Medicine, attracted more than 150 medical students.

Community Health Services

The School of Dentistry has for several years staffed with faculty and students a dental clinic in Venice, organized and directed by the Venice Health Council following a community health survey conducted by UC,LA public health and other students which disclosed that dental care was a high priority community need. More recently the UC,LA School of Dentistry has undertaken, jointly with the USC School of Dentistry, to operate a week-end mobile dental service for people in need in rural parts of southern California. A dentist who is now a candidate for the Doctor of Public Health degree in the School of Public Health has a major responsibility in this mobile program.

Many UC,LA students and members of the faculty volunteer considerable amounts of time in the many "free-clinics" in Los Angeles. Recent graduates and current faculty and students are now engaged in planning for a broad-based community health service in the Venice area. These activities tend to draw together students and faculty from the various health professional schools toward understanding and contributing to the solution of community health problems.

Curriculum

While the above-mentioned activities reveal the growing commitment of UC,LA as a whole to community medicine, the Department of Preventive and Social Medicine in the School of Medicine and the School of Public Health are particularly concerned with curriculum in this field. For some years these two academic elements have operated as a consortium faculty, for example, in teaching epidemiology to students in the School of Medicine and in the School of Public Health. They now have responsibility for a new course in Social Medicine for first-year medical students which will provide attention to (1) problems of minority segments of the population in obtaining medical care; (2) economic and social barriers to health care and current proposals for overcoming them; (3) primary care and new ways of providing it; and (4) special problems of migrant workers and others.

Following the course in Social Medicine during the Spring Quarter of the first year, students have an opportunity to obtain ten-week summer apprenticeships, mainly assisting in health care at places remote from the medical center. During the 1972 Summer, 20 UC,LA medical students worked in such situations as the rural Alaska health service, Indian reservations, farm workers health clinics, a community hospital having special language and other cultural problems with patients, and a small community in Oregon (to continue work in a "free-clinic" initiated by previous UC,LA students and supported by local physicians and the health department). Each student is supervised by a local physician and maintains contact with a faculty member during the summer. These experiences give students knowledge of some social aspects of medicine, experience in working effectively with people, and an

exhilaration for tackling major problems in medicine. More than 50 medical students in 1972 competed for the 20 places available in the apprenticeship program.

UC,LA also encourages medical students to participate in health work in other countries through a program sponsored by the Association of American Medical Colleges. For 1973, two students from UC,LA have been selected among 20 in the nation to work for ten weeks in the Yugoslavia health care system.

In the third-year pediatric rotation all students visit Venice and Imperial County for direct exposure to problems that people in poverty communities encounter in obtaining health care and various attempts to deal with these problems.

During their fourth year UC,LA students again have substantial opportunity to engage in social medicine, through preceptorships with (1) family physicians practicing in a rural or urban poverty neighborhood, a program initiated by a grant from the California Medical Education and Research Fund of the California Medical Association; (2) a family practice residency training program in a hospital located near UC,LA; (3) a college student health service, especially for study of health problems among adolescents; and (4) faculty members on special projects—for example, an excellent study by two students (one interested in psychiatry and one in public health) of emergency care services for the mentally ill patients in West Los Angeles.

Residency Training

UC,LA also offers an AMA Specialty Board-approved residency training program in preventive medicine, consisting of one year in clinical training, usually in some aspect of primary care provided by a UC,LA-related facility; one year devoted to work for the Master of Public Health degree in the School of Public Health; and one year to further study and experience involving a specific project in the field of preventive medicine. At present residents are engaged in: (1) development of a community health network, primary care linked with specialty and hospital care, under the auspices of an OEO-financed and consumer-led community health group; (2) a large-scale methadone treatment program for heroin addicts, extending from the campus into the community, under the auspices of the Department of Psychiatry; and (3) planning and initiation of a new family-oriented general medical service in a poor neighborhood, to replace the fragmented clinic services previously offered by Los Angeles County (as by most local health departments) in past years.

Research

Faculty at UC,LA have developed major investigations of such questions as the extent to which various types of health care plans (provider-sponsored, commercially-sponsored, and group practice-prepayment) meet the needs of their subscribers as viewed by those subscribers, as judged by provision of preventive medical services, and in other ways. Contracts with governmental agencies support efforts to determine the effectiveness, efficiency and other aspects of governmental medical care programs.

Graduate students, with faculty support, are engaged in such studies as: the extent to which new family practice residency training programs are achieving their objectives as seen by administrators, clinical teachers and residents; how those responsible for labor-management health care funds can evaluate the plans on which these funds are expended; how new types of health care personnel can be developed with emphasis on incorporating people living in the neighborhood being served into the health care system.

At UC,LA, therefore, the academic phase of community medicine—developing new types of service, education of physicians and other health care personnel in the ways of community medicine, and research on problems of community medicine—extends widely through the faculty and student body of the several schools in the Center for the Health Sciences.

Beyond that Center, the effort has increasing support among faculty of such schools as the Graduate School of Management and the School of Architecture and Urban Planning in helping to solve community medical problems. The National Health and Environmental Law Program (NHELP) on the campus has been deeply involved in securing the rights of persons eligible for public medical care programs, especially when these are impaired by administrative processes.

Off the campus, UC,LA is further related to community medicine—for example, through affiliation with the Department of Community Medicine at the Drew Postgraduate Medical School in

Watts. Members of the latter faculty have joint appointment at UC,LA and take part in the teaching program there; students and faculty from UC,LA take part in projects at the Drew School. Informal relationships extend from UC,LA to many other agencies engaged in community medicine including the Los Angeles County Department of Health Services and some of its hospitals and other units.

Thus UC,LA is participating on many fronts in the movement known as community medicine, to adapt medicine more closely to the needs of communities.

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THE CONCEPT OF A Department of Community Health in a medical school must be viewed in terms of the total mission of a medical school. Departments of community health should provide opportunities for students to learn about, and participate in, the delivery of health care. These opportunities would provide medical students with an invaluable window to the realities of medical practice that await them as graduating physicians of tomorrow.

In offering a definition of the function and purpose of departments of community health, it is perhaps useful to distinguish community health from public health—both products of traditions that are compatible in principle, but quite divergent in focus. As has become apparent in recent years, the maintenance of health and protection from disease is considered as a guaranteed right of each individual rather than a privilege. The implementation of programs dealing with maintenance of health and prevention of disease has been vested to the government agencies; national, state, and local. The function of these agencies has evolved and increased over the years to cover an entire spectrum of varied activities dealing with environmental sanitation on one hand and prevention of disease (and sometimes treatment—for example, venereal diseases) on the other. Most recently these agencies have become quite concerned and interested in methods of payment and financial aspects of medical care as well. Community health, on the other hand, is a product of the medical profession's long history of attention to the proper diagnosis and treatment of disease, comprising a complex and interrelated series of interests and activities that has been described as "the medical care delivery system," including the ability to pay for these services. Recent advances in medical technology, however, have promoted changes in the social and demographic composition of the population such as age distribution, increase in urbanization and higher levels of income and educational achievements. These changes, in turn, have created a demand for a special kind of medical care delivery both in scope of delivery and in financing. Also, these changes, along with their dramatic publicity, have caused the emergence of an informed and highly vocal public, concerned with issues that affect its health.

We believe that the medical profession's long-established concern for the individual patient and its recognition of these changes have led to the recently identified set of priorities that in themselves have encouraged the establishment of new departments in schools of medicine, known as departments of community medicine or community health.

A definition of community health, therefore, offers a deliberate formulation of a proposal, broad enough to anticipate insights still to be achieved within the entire philosophy of medical education. This proposal denotes a matrix of concern embracing the ecological, social, and economic aspects of the community. Hence, we consider departments of community health those academic and administrative units in medical schools that can best represent the concept of health as a dynamic, non-static force in the communities. It

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